



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

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## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

VISTA MEDICAL CENTER HOSPITAL  
4301 VISTA ROAD  
PASADENA TEXAS 77504

#### **Carrier's Austin Representative Box**

15

#### **Respondent Name**

JACOBS ENGINEERING GROUP INC

#### **MFDR Date Received**

JULY 13, 2006

#### **MFDR Tracking Number**

M4-06-7050-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary Dated July 13, 2006:** "Payment not in accordance with Acute In Patient Stop Loss per Fee Guideline. 150-(N) HB7 408.27(b) retains the 45-day, pay, reduce, deny or determine to audit a healthcare providers medical bill not later than the 45<sup>th</sup> day after the receipt of medical bill, an insurance Carrier may request additional documentation to clarify the healthcare providers charges at any time during the 45 day review period. Carrier did not forward an explanation [sic] of missing documentation with 45 days in compliance. All required documentation has been forwarded to Carrier."

**Requestor's Supplemental Position Summary Dated October 27, 2011:** "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment...The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least two reasons...The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons..."

**Amount in Dispute:** \$61,358.26

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary Dated September 9, 2011:** "The referenced file has been assigned to us for submission of a Supplementing Position Statement. To accomplish this we have submitted a Form DWC-153, requesting the MFDR File. We can file a position statement shortly after receipt of the file requested."

**Response Submitted by:** Downs Stanford, P.C.

**Respondent's Supplemental Position Summary Dated November 17, 2011:** "...an unremarkable hospital stay involving the exact services anticipated and nothing beyond routine post-operative care, by definition, does not trigger or qualify for reimbursement per the stop-loss exception. While the services provided were not unusually costly to the hospital, they were unusually proceed to the carrier. This does not qualify the services for the stop-loss exception. **Bottom Line:** The Requestor has been overpaid under applicable fee guideline. No additional payment is due."

**Response Submitted by:** Downs Stanford, P.C., 115 Wild Basin Road, Suite 207, Austin, TX 78746

## SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
September 17, 2005 through September 19, 2005	Inpatient Hospital Services	\$61,358.26	\$0.00

## FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### Background

1. 28 Texas Administrative Code §133.304, 17 *Texas Register* 1105, effective February 20, 1992, amended effective July 15, 2000 sets out the procedures for medical payments and denials
2. 28 Texas Administrative Code §133.305 and §133.307, 27 *Texas Register* 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.600, 29 *Texas Register* 2360, effective March 14, 2004, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
5. 28 Texas Administrative Code §134.1, 27 *Texas Register* 4047, effective May 16, 2002, sets out the guidelines for a fair and reasonable amount of reimbursement in the absence of a contract or an applicable division fee guideline.

The services in dispute were reduced/denied by the respondent with the following reason codes:

#### Explanation of Benefits

- W1 – Workers compensation state fee schedule adjustment
- 42-Charges exceed our fee schedule or maximum allowable amount.
- 97 – Payment included in the allowance for another service/procedure.
- 150-Payment adjusted because the payer deems the information submitted does not support this level of service.
- 18-duplicate claim/service.
- 50-These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.
- W3-Additional payment made on appeal/reconsideration.
- W4-No additional reimbursement allowed after review of appeal/reconsideration.

### Issues

1. Did the audited charges exceed \$40,000.00?
2. Did the admission in dispute involve unusually extensive services?
3. Did the admission in dispute involve unusually costly services?
4. Does a medical necessity issue exist?
5. Is the requestor entitled to additional reimbursement?

### Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 *Texas Register* 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above

was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services **in this case** are unusually extensive; and whether the admission and disputed services **in this case** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection..." 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "...Audited charges are those charges which remain after a bill review by the insurance carrier has been performed..." Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal \$101,012.01. The Division concludes that the total audited charges exceed \$40,000.
2. The requestor in its letter requesting reconsideration asserts that "...TWCC Rule 134.401 requires payment of 75% of audited charges for billed charges that reach the stop-loss threshold of \$40,000.00." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

"The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least two reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed."

The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

3. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

“The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers’ compensation inpatient surgeries is \$23,187; the median charge for workers’ compensation surgeries of this type is \$39,000; therefore, the audited billed charges for this surgery substantially exceed not only the median charges, but also the \$40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of the surgery in comparison to other types of surgeries; and third, it was necessary to purchase expensive implants for use in the surgery.”

The requestor asserts that because the **billed charges** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the **costs** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor’s position that the admission is unusually costly based on the mere fact that the billed or audited charges “substantially” exceed \$40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in other types of surgeries.

4. According to the explanation of benefits dated November 14, 2005, the respondent denied reimbursement of \$17.40 for patient convenience items; \$790.52 for unlisted special service; and \$1984.00 for unlisted special service based upon reason code “50”.

28 Texas Administrative Code §134.600(h)(3) states “Non-emergency health care requiring preauthorization includes: (3) spinal surgery, as provided by Texas Labor Code §408.026.”

On August 19, 2005, the respondent’s representative, Intracorp, gave preauthorization approval for “Anterior Cervical Discectomy Fusion C5-6 and 2 inpatient days in an Acute Hospital setting.”

Therefore, the spinal surgery and related services were preauthorized and the medical necessity issue is not supported for the unlisted special services billed at \$790.52 and \$1984.00.

For the charges of \$17.40 relating to patient convenience items, 28 Texas Administrative Code §134.401(c)(6)(A)(v) states, “Audited charges are those charges which remain after a bill review by the insurance carrier has been performed. Those charges which may be deducted are personal items (e.g., telephone, television).” Therefore, the respondent’s denial of patient convenience items is supported.

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements*. The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.
  - Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that “The applicable Workers’ Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission...” The length of stay was two days. The surgical per diem rate of \$1,118 multiplied by the length of stay of four day results in an allowable amount of \$2,236.00.
  - 28 Texas Administrative Code §134.401(c)(4)(A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).”
  - A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at \$31,400.00.

- The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Cost Invoice	Cost + 10%
ACIF Cage	1	\$2800.00	\$3080.00
Plate CCM	1	\$3250.00	\$3575.00
Screw CCM	4	\$450.00/each	\$1980.00
TOTAL	6		\$8635.00

- 28 Texas Administrative Code §134.401(c)(4)(C) states "Pharmaceuticals administered during the admission and greater than \$250 charged per dose shall be reimbursed at cost to the hospital plus 10%. Dose is the amount of a drug or other substance to be administered at one time." A review of the submitted itemized statement finds that the requestor billed \$425/unit for Morphine PCA. The requestor did not submit documentation to support what the cost to the hospital was for these items billed under revenue code 250. For that reason, additional reimbursement for these items cannot be recommended.

The division concludes that the total allowable for this admission is \$10,871.00. The respondent issued payment in the amount of \$14,400.75. Based upon the documentation submitted no additional reimbursement can be recommended.

### **Conclusion**

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount*, and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

		8/24/2012
Signature	Medical Fee Dispute Resolution Officer	Date

		8/24/2012
Signature	Medical Fee Dispute Resolution Manager	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**